STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of
XXXXX
Petitioner **File No. 122032-001-SF**

v
Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 18th day of January 2012
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On June 23, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006, MCL 550.1951 *et seq.* The Commissioner reviewed the material submitted and accepted the request on June 30, 2011.

The Petitioner receives health coverage through Wayne County, a governmental self-funded group. The plan is administered by Blue Cross and Blue Cross of Michigan (BCBSM). Her benefits are defined in BCBSM's *Dental Options Group Benefit Certificate* (the certificate). The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on July 14, 2011.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.*

Because it involved medical issues the case was assigned to an independent review organization which provided its analysis and recommendations to the Commissioner on July 21, 2011.

II. FACTUAL BACKGROUND

On January 18, 2010, the Petitioner had a crown placed on tooth #30. BCBSM denied coverage, having concluded that the crown was not medically necessary and therefore not a covered benefit. The amount charged for this care was $899.00.

The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference on April 21, 2011, and issued a final adverse determination dated September 1, 2011, upholding its denial.

III. ISSUE

Did BCBSM properly deny coverage for the crown on tooth #30 provided on January 18, 2010?

IV. ANALYSIS

Petitioner's Argument

The Petitioner argues that her dentist determined the crown was medically necessary treatment of tooth #30 and there is documentation to support the necessity for this covered benefit. Therefore, she wants BCBSM to provide coverage for the crown under the terms of the certificate.

BCBSM's Argument

In its final adverse determination, BCBSM explained that its coverage of crowns is limited to situations when a tooth cannot be restored with materials such as amalgam, composite or resins for person 12 years of age or older.

BCBSM maintains that tooth #30 could have been restored to a professionally acceptable level with a conventional "direct fill" restoration, either a composite or amalgam. Therefore, a crown is greater than what is required for the plan to cover.

Commissioner's Review

While the Petitioner's external review was being processed at OFIR, BCBSM, at the Commissioner's request, re-evaluated the claim and determined that it would pay its approved amount for a less costly direct fill restoration. On December 28, 2011, BCBSM issued a check for $113.00 to the Petitioner's dentist in payment of the less costly procedure. Because the Petitioner's appeal involved a claim larger than the amount tendered by BCBSM, the Commissioner's external review continued.

The Petitioner's certificate (page 3.5) provides coverage for crowns to restore decay or fractured teeth as follows:

> **Section 3: Coverage for Dental Services**
> **CLASS II - Restorative Services**
> We pay our approved amount for the restorative services listed below when performed by a dentist to restore decayed or fractured teeth. Restorative services are Type A services, except where noted.
>
> * * *
>
> **Onlays, crowns** and **veneers** when a tooth cannot be restored with materials such as amalgam, composite or resins for persons 12 years of age or older.

In addition, the certificate (page 4.1) lists dental services that are not covered:

> **Section 4: Dental Services That Are Not Covered**
> The more costly treatment when two or more methods are available to treat a condition. We pay the approved amount, less the required copayment and deductible, if any, for the less costly acceptable standard of treatment.

The question of whether Petitioner's crown was medically necessary was presented to an independent review organization (IRO) for analysis as required by section 11(6) of the PRIRA, MCL 550.1911(6). The IRO reviewer is a doctor of dental medicine in active practice. The reviewer is a member of the American Dental Society and the Academy of General Dentistry. The reviewer provided the following analysis and conclusion:

> It is the determination of this reviewer that a crown was not medically necessary.
>
> * * *
>
> The records submitted for review are silent to whether the enrollee had a chief complaint concerning tooth #30. The records are also silent to whether or not the tooth was tested for hot or cold sensitivity or fractured cusps.
>
> The periapical radiograph submitted for review does not show the apices of tooth #30. In this respect this particular X-ray is clinically not to the standard of care in that it does not provide a picture of the entire tooth.
>
> The digital picture presented for review shows a large occlusal amalgam. The remainder of the tooth is intact. The digital periapical shows a deep amalgam restoration present. The mesial, distal, buccal and lingual walls of the tooth are intact leaving it with much of its original strength.
>
> The health plan Section 3: Coverage for Dental Services indicates that coverage will be provided for 'Onlays, crowns and veneers when a tooth cannot be restored with materials such as amalgam, composite or resins for persons 12 years of age or older.' Based on the documentation and photos submitted for review, the

> enrollee's lower first molar (tooth #30) did not merit a full coverage restoration and could be restored with composite.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded deference by the Commissioner. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b). The IRO reviewer's analysis is based on extensive expertise and professional judgment and the Commissioner can discern no reason why that judgment should be rejected in the present case. The Commissioner finds that the crown on tooth #30 was not medically necessary.

V. ORDER

BCBSM's April 29, 2011, final adverse determination is upheld. BCBSM is not required to provide coverage for the Petitioner's crown.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this order may seek judicial review no later than 60 days from the date of this order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, P.O. Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner